ATTACHMENT C

- **Service Satisfaction Report (to be completed by DCS Staff)**
- **Instructions for Progress Report and Program Evaluation**
- **Program Progress Report for Title IV-B Part I and II, SSBG, CFCIP**
- **Evaluation Format**
  1. **Title IV-B Part I and II, SSBG**
     - **Annual Evaluation Report**
     - **Annual Evaluation of Service Outcomes**
     - **Annual Evaluation Narrative**
  2. **Chafee Foster Care Independence Program (CFCIP)**
     - **Face Sheet for Mid-Year Report**
     - **Code Sheet for CFCIP Demographic Mid-Year Report**
     - **CFCIP Mid-Year Demographic Report**
     - **CFCIP Mid-Year Spending Progress Report**
     - **Services Progress Report Cover Sheet**
     - **Annual Evaluation Report**
     - **Annual Evaluation of Service Outcomes**
     - **Annual Evaluation Narrative**
     - **CFCIP Year End Program Report**
     - **Client Tally Sheet**

SERVICE SATISFACTION REPORT

To be completed by the DCS staff on each contracted service provider

PROGRAM:_____ **PROVIDER:**_____

FISCAL YEAR:_____ **DATES OF EVALUATION:**_____**to** _____

ANSWER ALL THE FOLLOWING QUESTIONS IN TERMS OF THE PROPOSAL AS YOU UNDERSTAND THE PROGRAM IS TO BE ADMINISTERED. FOR EACH QUESTION THAT YOU ANSWER WITH A "1" OR "2", PLEASE UTILIZE THE BACK OF THIS PAGE TO PROVIDE DETAILS OF CONCERNS OF THE DCS AND SUGGEST A SOLUTION.

Section I: Answer the following questions for the above program serving your county.

Answer the following on a scale of 0 to 5 using the definitions below:
5 = Strongly Agree, 4 = Agree, 3 = Somewhat Agree, 2 = Disagree, 1 = Strongly Disagree, 0 = not applicable

____1. The service provider is cooperative, professional, and productive in carrying out this program for our county.

____2. The service provider demonstrates knowledge of all aspects of the job.

____3. The service provider has a working knowledge of available services in the county/surrounding area and how to assist the clients in accessing them.

____4. The service provider meets our expectations regarding scheduling and maintaining appointments with the referred clients and is prompt for all scheduled appointments.

____5. The service provider provides adequate and timely verbal progress updates as well as written reports and is available for court testimony when requested by the referral source or court.

____6. The service provider uses sound judgment in carrying out work activities.

____7. The service provider initiates interaction and works effectively with the DCS director and staff, referred clients, and other agencies.

____8. The program is utilized appropriately in regard to a reasonable length of service for each referral.

____9. Feedback from clients referred to the program indicates that they are satisfied with the provider's scheduling practices, promptness for appointments, and overall method of service delivery.

___10. The service provider initiates services within a reasonable time frame from the date of referral to the date of initial contact.

___11. The service provider is responsive in addressing concerns of the DCS and/or referred client promptly that are brought to their attention.

Section II. Answer the following questions if this program provides "Family Preservation, Time Limited Reunification and/or Adoption Promotion-Support" services; it has the goal of maintaining/reunifying families.

____1. This program service meets our expectations of strengthening referred families skills and/or maintaining children safely in their own home.

____2. This program assists in reducing the length of stay in substitute care and/or stabilizes reunification, when these are the goals.

____3. Appropriate intervention plans are developed with input from the client and DCS Family Case Manager that support the goals and objectives of the child's case plan.

Date:_____ **Signature:**_____
Title:_____ **County:**_____

INSTRUCTIONS FOR Child Welfare Services Provider Program Evaluation

(1) As Stated in the proposal.

(2-3) Self explanatory.

Complete #4,#5, and/or #6 as applicable to service and as stated in the Proposal.

(4) "Total Clients Served" is defined as the number of different adults and children served directly (e.g. face-to-face service contact) by the program.**

(5) "Total Children Served" is defined as the number of different children served directly (e.g. face-to-face service contact) by the program.**

For Family-Centered Programs (e.g. Intensive Caseworkers, Homemakers, Home-Based Therapist): "Total Children Served" is defined as the total number of children in the families served who benefited from the service (regardless of whether child(ren) were directly served).**

For Sexual Abuse Treatment and Counseling Services: "Total Children Served" is defined as the number of different children served directly (e.g. face-to-face service contact) by the program. **

(6) "Total Families Served" is defined as the primary caretaker(s) (as defined in CWATS) with their children. Count foster parents as separate family units only when the goal was to avoid foster family disruption or for permanency planning. For sexual abuse programs, if the perpetrator is being served and is a parent, guardian, custodian, or relative (e.g. live-in boyfriend, father , step-father, grandfather, uncle) - whether in or out of the home it is considered one family unit: if the perpetrator is a non-familial (e.g. baby-sitter, neighbor, stranger),. it is considered separate family units.**

(7) "Race of family" identified by the race of the family/client that was referred (Total in #8 should equal the number of families in #7). If more than one racial group is represented in the family, the family shall be considered bi-racial.

(8) As stated in the contract.

(9) As stated in the contract.

(10) Number of units provided and billed for the evaluation period

(11) Actual unit cost of this service as per the provider internal cost accounting procedures. Attach documentation.

(12) The dollar amount the actual unit cost was above or below the contracted unit rate.

(13) Average length of service for discharged CL/CH/FA, circle one, regardless of funding year.

(14) Average # of units of service for discharged CL/CH/FA, circle one, regardless of funding year.

(15) The total of all claims billed to this program.

(16) Total Cost of Services provided divided by the total CL/CH/FA (circle one) served (#4, 5 or 6)

(17-20) Self explanatory. Enter the start date of the program as stated in the contract.

(21) Only count a family as discharged when everyone in that family unit that was being served has been discharged. (Total in #19 should equal 21a through 21m)

(22) "Families Completing Planned Service" should be equal to 23a. Calculated as follows: Total Cost Billed per Family Completing Service (from first date of service to date of discharge) ÷ Total Number of Families Completing Service.

(23) "Families Not Completing Planned Service" should be equal to 23b through 23f. Calculated as follows: Total Cost Billed per Family Not Completing Service (from first date of service to date of discharge) ÷ Total Number of Families Not Completing Service.

* If you define "Client", "children" or "family" differently than stated here, state the definition in a footnote on the Summary Sheet.

CHILD WELFARE SERVICES PROVIDER PROGRAM EVALUATION FOR _____REGION
EVALUATION PERIOD: 07/01/0_____ TO 06/30/0_____

(1) TITLE OR PROGRAM: _____
(2) SERVICE PROVIDER: _____
(3) COUNTIES SERVED: _____

TOTAL **(4)** CLIENTS SERVED: _____ **(7)** RACE OF CLIENT/CHILD/FAMILY (# in each Category)
(5) CHILDREN:_____ WHITE BLACK HISPANIC NATIVE AMER. BI- RACIAL
(6) FAMILIES:_____ _____ _____ _____ _____ _____

(8) Service Unit	**(9)** Unit Billing Rate	**(10)** Number of Units Provided	**(11)** Actual Provider Cost/Unit	**(12)** Unit Cost Over or Under Proposal	**(13)** Average length of service discharged Client/Child/Family	**(14)** Average # Service units Discharged Client/Child/Family
A.						
B.						
C.						
D.						
E.						

(15) TOTAL TITLE IV-B COST of the Program for Services Provided			**(16)** Average Cost for Services Provided by:	
IV-B PART I			Client	
IV-B PART II			Families	
COUNTY FUNDING			Children	

(17) # FAMILIES In Program 10/01/04	
(18) # NEW FAMILIES Admitted Since 10/01/04	
(19) # FAMILIES Discharged 10/01/04-09/30/05	
(20) # FAMILIES in Program 09/30/05	

(21) DISCHARGE BY REASON (Refer to number in # 19):	Number of Families
a. Completing planned service	
b. Parents(s) incarcerated	
c. Client refused to initiate services	
d. Client withdrew from services	
e. DCS withdrew family	
f. Agency withdrew family	
g. Client referred to another service (same agency)	
h. Client referred to another agency	
i. Client moved from service area	
j. Client incarcerated	
k. Client moved to another funding source	
l. Parental rights terminated	
m. Other (explain)	

(22) ***TOTAL*** average cost per family completing the planned service (refer to discharge reason "a.")
Include costs from all applicable funding years: $_____
(23) ***TOTAL*** average cost per family ***NOT*** completing the planned service.
Include costs from all applicable funding years: $_____

COMPLETED BY: Name _____ Position _____

Telephone Number: _____ Date: _____

IV-B PART I, IV-B PART II, and SSBG SERVICES
ANNUAL EVALUATION REPORT FOR REGION

EVALUATION PERIOD: _____/ _____/_____ To _____/ _____/_____

SERVICES OUTCOMES

List below the outcome objectives of the program as stated on the program summary sheet. Include both the proposed outcomes and the achieved outcomes using the measurement criteria included in the proposed outcomes.

PROPOSED:

ACHIEVED:

PROPOSED:

ACHIEVED:

PROPOSED:

ACHIEVED:

PROPOSED:

ACHIEVED:

IV-B PART I, IV-B PART II. & SSBG SERVICES
ANNUAL EVALUATION REPORT FOR REGION

EVALUATION PERIOD: _____/ _____/_____ TO _____/ _____/_____

EVALUATION NARRATIVE

A. Briefly describe, on pages to be attached, the program as it was delivered. Include any changes or modifications made since the original proposal, as well as the purpose of all changes.

B. If for any objective, the outcome percentages or numbers are below those stated in the program summary sheet, state why this has occurred and suggest changes that might improve the program's future success.

C. If for any objective, the outcome percentages or numbers meet or exceed those stated in the program summary sheet, comment briefly on the elements of the program that have proved to be particularly helpful.

D. Identify/discuss achievements that were realized as a result of the program that were not included as part of the original proposal.

FACE SHEET

Format for Submitting CFCIP Mid-Year Report

Region: _____

Title of Project: _____

Provider Name: _____

Counties Served: _____

Date Submitted: _____

Attach the following items to this face sheet and mark (x) those attached:

_____ **Description of services provided including program modifications and current status of implementation**

_____ **Spending Progress Report**

_____ **Statement indicating how funding assisted youth toward transition**

_____ **If room and board expenses were paid, give a separate accounting for those expenses.**

Provider: Submit Face Sheet and attachments to Regional Coordinator at:

_____
_____
_____
_____

Coordinator: After examining reports for completeness and accuracy submit to:

MS-08, ATTN: Programs and Services
Department of Child Services
402 West Washington Street, W 364
Indianapolis, IN 46204-2773

MID-YEAR CFCIP SPENDING PROGRESS REPORT

The purpose of this report is to inform the Department of Child Services of CFCIP expenditures and plans for the remaining balance.

Region	**Date**
Contact Person	**Telephone Number**
Amount of Allocation	**Number of CFCIP Clients**

A. Amount spent up to 11/30_____ **B. Balance Remaining**_____

C. Indicate your plan for use of remaining balance:

Budget Item	**Budget Amount**	**Target date for expenditure**

D. Identify existing barriers to the implementation of your plan.

E. Amount available for external transfer (Attach Form 660)

Return to : MS-08 ATTN: Programs and Services
Department of Child Services
402 W. Washington Street, Room W 364
Indianapolis, IN 46204-2773

CFCIP SERVICES
PROGRESS REPORT COVER SHEET FOR REGION

[1] Evaluation Period: _____/ _____/_____ To _____/ _____/_____

[2] Title Of Program:_____

[3] Service Provider:_____

[4] Counties Served:_____

[5] Clients Served: **Total** _____

[9] Type Of Service Unit (As Per The Contract)	**[10] Billing Rate**	**[11] Total # Of Units Proposed (6 Months)**	**(12) Total # of Units Provided (6 Months)**
A.			
B.			
C.			
D.			
E.			
F.			

[17] Total Cost Of The Program For Services Provided: $_____

[18] Average Cost Per CLIENT For Services Provided This Period: $_____

Comments:

Completed By:_____ **Position:**_____ **Date:**_____

Telephone Number:_____

CFCIP SERVICES ANNUAL EVALUATION REPORT FOR REGION

[1] Evaluation Period: _____/ _____/_____ TO _____/ _____/_____

[2] Title Of Program:

[3] Service Provider:

[4] Counties Served:

[5] Clients Served: TOTAL _____

[8] Race Of Client/Child/Family (# In Each Category)

White (Not Hispanic)	Black	Hispanic	Asian	Native American	Bi-Racial

	[9] Define Each Service Unit (As Per the Contract)	[10] Billing Rate	[11] Total # Of Units Proposed	[12] Total # Of Units Provided
A.				
B.				
C.				
D.				
E.				
F.				

	[13] Service Unit Actual Provider Cost/Unit	[14] Unit Cost Over Or Under Proposed	[15] Average Length Of Service/Disc Client	[16] Average # Service Units/Disc Client
A.				
B.				
C.				
D.				
E.				

[17] Total Cost Of The Program For Services Provided:_____

[18] Average Cost Per CLIENT For Services Provided:_____

[19] # CL in Program __/__ _____

[20] # new CL admitted since __/__

[21] # CL discharged __/__ to __/__ _____

[22] # CL in program __/__

[23] Discharge By Reason:

A) ____ # Of Youth Completed Planned Service
B) ____ # Of Youth Moved/Unable To Locate
C) ____ # Of Youth Who Refused Service/Uncooperative
D) ____ # Of Youth For Whom Service Not Appropriate
E) ____ # Of Youth Not Amenable To Service
A) ____# For Other Reason(s):

[24] Total average cost per youth completing (discharge reason "a") the planned service. Include costs from all applicable funding years: $_____

[25] Total average cost per youth not completing (discharge reasons "b" through "f") the planned service. Include costs from all applicable funding years: $_____

Completed By: Name:_____ Position:_____ Date:_____

Telephone Number:_____Email Address:_____

CFCIP SERVICES ANNUAL EVALUATION REPORT FOR REGION

EVALUATION PERIOD: _____/ _____/_____ To _____/ _____/_____

SERVICES OUTCOMES

List below the outcome objectives of the program as stated on the program summary sheet. Include both the proposed outcomes and the achieved outcomes using the measurement criteria included in the proposed outcomes.

PROPOSED:

ACHIEVED:

PROPOSED:

ACHIEVED:

PROPOSED:

ACHIEVED:

PROPOSED:

ACHIEVED:

CFCIP SERVICES ANNUAL EVALUATION REPORT FOR REGION

EVALUATION PERIOD: _____/ _____/_____ TO _____/ _____/_____

EVALUATION NARRATIVE

A. Briefly describe, on pages to be attached, the program as it was delivered. Include any changes or modifications made since the original proposal, as well as the purpose of all changes.

B. If for any objective, the outcome percentages or numbers are below those stated in the program summary sheet, state why this has occurred and suggest changes that might improve the program's future success.

C. If for any objective, the outcome percentages or numbers meet or exceed those stated in the program summary sheet, comment briefly on the elements of the program that have proved to be particularly helpful.

D. Identify/discuss achievements that were realized as a result of the program that were not included as part of the original proposal.

CFCIP YEAR END PROGRAM REPORT

Region: _____

Title of Project: _____

Provider Name: _____

Counties Served: _____

_____

Date Submitted: _____

Attach the following to this face sheet:

_____ **Year-end Program Report Form**

_____ **660 Form**

_____ **Individual narrative**

_____ **Client Tally Sheet**

_____ **Recommendations for program modifications**

_____ **Room and Board Report**

Provider: Submit Face Sheet and Attachments to Regional Coordinator at:

_____
_____
_____
_____

Coordinator: After examining reports for completeness and accuracy, attach Narrative Evaluation of Regional IV-E IL Program(s) and submit to:

MS-08, ATTN: Programs and Services
Department of Child Services
402 West Washington Street, W364
Indianapolis, IN 46204-27723

To be submitted no later than July 31st
Region: _____
(for period July 1st to June 30th)

Project Title:_____
Provider Name:_____

CLIENT TALLY SHEET

Description of CFCIP Eligible Population Served by Provider

1. _____ Total youth served

1. **_____ Number of youth who received CFCIP services, but withdrew before completing entire program**

2. Age
- **_____ 14 years**
- **_____ 15 years**
- **_____ 16 years**
- **_____ 17 years**
- **_____ 18 years**
- **_____ 19 years**
- **_____ 20 years to 20 y, 11 mo, 29 day**
- **_____ TOTAL (must agree with # 1)**

3. Gender
- **_____ Male**
- **_____ Female**
- **_____ TOTAL (must agree with # 1)**

4. Race
- **_____ White**
- **_____ Hispanic**
- **_____ Black**
- **_____ Asian or Pacific Islander**
- **_____ Native American or Native Alaskan**
- **_____ Bi-racial**
- **_____ Missing data**
- **_____ TOTAL (must agree with # 1)**

5. Living arrangement of Youth
- **_____ Licensed Foster Home**
- **_____ Group Home**
- **_____ Living Independently**
- **_____ Correctional/Child Caring Institution**
- **_____ Legal Guardian's Home**
- **_____ Relative Home**
- **_____ Own Home/reunified with parents**
- **_____ Other**
- **_____ TOTAL (must agree with # 1)**

6. _____ Special Needs (unduplicated)
Community Service
Special Needs defined as:
-Emotional Disturbance
-Developmentally Disabled
-Diagnosed Specific Learning Disability
-Hearing, Speech, or Sight Impairment
-Other Physical Handicap
-Medical Condition-Clinically Diagnosed
-Race
-Sibling Group (needing IL services does not qualify as a special need)

7. Marital Status of Youth
- **_____ Unknown**
- **_____ Single**
- **_____ Married**
- **_____ Divorced**
- **_____ TOTAL (must agree with # 1)**

8. Parental Status of Youth
- **_____ No Children**
- **_____ One (1) Child**
- **_____ Two or more Children**

9. In foster care
- **_____ Less than 6 months**
- **_____ Between 6 months and 12 months**
- **_____ Between 1 and 2 years**
- **_____ Between 2 and 3 years**
- **_____ Between 3 and 4 years**
- **_____ Between 4 and 5 years**
- **_____ Between 5 and 7 years**
- **_____ Between 7and 10 years**
- **_____ Between 10 and 12 years**
- **_____ Between 12 and 15 years**
- **_____ More than 15 years**
- **_____ Unknown**
- **_____ TOTAL (must agree with # 1)**

10. _____ Number of youth who have completed CFCIP program

11. 90 day Status of youth who have completed CFCIP program
- **_____ Employed**
- **_____ Obtained High School diploma or GED**
- **_____ Obtained housing and/or other living independently of agency maintenance program**